BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of: DOMINIK L. Claimant, vs. SAN GABRIEL/POMONA REGIONAL CENTER, Service Agency.	OAH No. 2013070171

PROPOSED DECISION

This matter came on regularly for hearing on August 9, 2013, in Pomona, California, before H. Stuart Waxman, Administrative Law Judge, Office of Administrative Hearings, State of California.

Dominik L.[1] (Claimant) was represented by Anne L, Claimant's aunt and authorized representative.

San Gabriel/Pomona Regional Center (Service Agency) was represented by Daniela Martinez, Fair Hearing Manager.

Oral and documentary evidence was received. The record was closed on the hearing date, and the matter was submitted for decision.

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[1] Initials are used in lieu of Claimant's surname and those of his relatives in order to protect their privacy.

ISSUE

The parties stipulated that the sole issue in this matter is whether Claimant is eligible for regional center services by virtue of a diagnosis of autism[2] or a condition similar to mental retardation or one requiring treatment similar to that required for mentally retarded individuals (also known as the "fifth category").

EVIDENCE CONSIDERED

1. Exhibits 1 through 7
2. Exhibits A through C
3. Testimony of Deborah Langenbacher, Ph.D.
4. Testimony of Anne L.
5. Testimony of Jocie J.
6. DSM-IV-TR
7. DSM-5

FACTUAL FINDINGS

1. Claimant is a seven-year-old boy who lives with his aunt, Anne L. He claims to suffer from autism or a condition similar to mental retardation or one requiring treatment similar to that required for mentally retarded individuals (fifth category).

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[2] As is more fully set forth below, "autism" is no longer considered a separate disorder, but has been subsumed under the broader umbrella of autistic spectrum disorder.

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2. Until recently, autism was diagnosed using the criteria set forth under the name Autistic Disorder in the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth edition, text revised (DSM-IV-TR) published by the American Psychiatric Association. Between the time of Claimant's most recent evaluation and the date of the hearing in this matter, DSM-IV-TR was succeeded by DSM-5.[3] DSM-5 no longer recognizes a specific diagnosis of autistic disorder. Instead, it established a diagnosis of autism spectrum disorder which encompassed disorders previously referred to as early infantile autism, childhood autism, Kanner's autism, high-functioning autism, atypical autism, pervasive developmental disorder not otherwise specified, childhood disintegrative disorder, and Asperger's disorder. (DSM-5, page 53.) All of Claimant's evaluations were performed before DSM-5 was released, and they referred to the diagnostic criteria set forth in DSM-IV-TR. However, the diagnostic criteria for Autism Spectrum Disorder in DSM-5 differ to a certain degree from those of Autistic Disorder in DSM-IV-TR. Therefore, the data contained in the evaluations, and Claimant's condition, were addressed at the hearing using both the criteria in DSM-IV-TR and those in DSM-5. This Decision will do the same.

3. Under DSM-IV-TR, the diagnostic criteria for autistic disorder were:

A. A total of six (or more) items from (1), (2), and (3), with at least two from (1), and one each from (2) and (3):

(1) qualitative impairment in social interaction, as manifested by at least two of the following:

(a) marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction

(b) failure to develop peer relationships appropriate to developmental level

(c) a lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest)

(d) lack of social or emotional reciprocity

(2) qualitative impairments in communication as manifested by at least one of the following:

[3] The Administrative Law Judge takes official notice of the DSM-IV and its successor DSM-5 as highly respected and generally accepted tools for diagnosing mental and developmental disorders.

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(a) delay in, or total lack of, the development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime)

(b) in individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others

(c) stereotyped and repetitive use of language or idiosyncratic language

(d) lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level

(3) restricted repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one of the following:

(a) encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus.

(b) apparently inflexible adherence to specific, nonfunctional routines or rituals

(c) stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole body movements)

(d) persistent preoccupation with parts of objects

B. Delays or abnormal function in at least one of the following areas, with onset prior to age 3 years: (1) social interaction, (2) language as used in social communication, or (3) symbolic or imaginative play.

C. The disturbance is not better accounted for by Rett's Disorder or Childhood Disintegrative Disorder.

(DSM-IV-TR, page 75)

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4. The DSM-5 diagnostic criteria for autism spectrum disorder are as follows:

A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history (examples are illustrative, not exhaustive . . .):

1. Deficits in social-emotional reciprocity, ranging for example, from abnormal social approach and failure of normal back-and-forth conversation, to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.

2. Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication, to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.

3. Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.

Specify current severity:

Severity is based on social communication impairments and restricted, repetitive patterns of behavior . . .

B. Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history (examples are illustrative, not exhaustive . . .):

1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypes, lining up toys or flipping objects, echolalia, idiosyncratic phrases).

2. Insistence of sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat same food every day).

3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests).

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4. Hyper- or hyporeactivity to sensory input or unusual interest in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).

Specify current severity:

Severity is based on social communication impairments and restricted, repetitive patterns of behavior . . .

C. Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies in later life).

D. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.

E. These disturbances are not better explained by intellectual disability (intellectual developmental disorder) or global developmental delay. Intellectual disability and autism spectrum disorder frequently co-occur; to make comorbid diagnoses of autism spectrum disorder and intellectual disability, social communication should be below that expected for general developmental level

Note: Individuals with a well-established DSM-IV diagnosis of autistic disorder, Asperger's disorder, or pervasive developmental disorder not otherwise specified should be given the diagnosis of autism spectrum disorder. Individuals who have marked deficits in social communication, but whose symptoms do not otherwise meet criteria for autism spectrum disorder, should be evaluated for social (pragmatic) communication disorder.
(DSM-5, pages 50-51.) (Emphasis in text.)

5. On December 24, 2008, Marta Schmidt-Mendez, M.A. performed a developmental assessment on Claimant, who was then almost 30 months of age. Contrary to the testimony of Claimant's aunt, Anne L., Ms. Schmidt-Mendez wrote: "There is no reported family history of developmental disability." (Exhibit 3, page 1.) During the evaluation, Claimant was initially shy, but was later able to engage with the examiner. Claimant had good attention span until language tasks were presented. He spoke words but was difficult to understand. Family members reported that Claimant was social and enjoyed engaging with other children. However, he did not have many opportunities to be around other children.

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6. According to an Individualized Education Program (IEP) from his school district, dated March 26, 2012, Claimant exhibited an articulation delay and was found eligible for special education based on speech or language impairment. However, it was decided that he would remain in and participate in the general education environment 97 percent of the school day.

7. According to an IEP from his school district, dated February 12, 2013, Claimant exhibited articulation and syntax/morphology delays and was found still eligible for special education based on speech or language impairment. He continued to remain in and participate in the general education environment 97 percent of the school day.

8. On March 26, 2013, a Social Assessment was performed on Claimant by a Service Agency intake vendor. Claimant was six years and eight months old at the time of that assessment. He had previously been evaluated by a different regional center. The records of that evaluation did not indicate mental retardation or autistic disorder. The evaluator in the March 2013 assessment described Claimant, in part, as follows:

> **Independent Living Domain/Self-help:** According to school reports [Claimant] can be shy at the beginning when first meeting people but he talks to others once he has "warmed up". He is said to have many friends in class. He is reported to get along well with peers and adults. His aunt indicates that [Claimant] does not have friends in the neighborhood. She said he is not interested. During this interview, [Claimant] responded to questions asked of him. He also asked questions and smiled easily. He enjoyed playing with the available toys in the room quietly and many times he sought approval from his grandmother when he had assembled something with the blocks available. A couple of times he stopped playing and approached his grandmother or his aunt and hugged them. He provided adequate eye contact. Aunt reports that she has tickets for Disneyland for the year and she takes [Claimant], his brother and cousins almost every weekend. Aunt reports that [Claimant] does not enjoy outings very much, he would rather stay home. It is said that [Claimant's] attention span is more than 30 minutes. Regarding his **Emotional Domain**, Aunt reports that [Claimant] is not friendly with his little brother and that sometimes he is aggressive with him.
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> **Cognitive Domain:** [Claimant] is able to write his name independently, colors pictures within the lines. He can count to a hundred and he can add single digits. He is said to recognize some words. His aunt reports that he is good at math. He enjoys playing games in the computer. He keeps his attention focused on a preferred activity for more than 30 minutes. [Claimant] is able to follow directions.

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> **Communication Domain:** According to the last IEP dated 2/12/13 completed by [Claimant's school district], [Claimant] has strong verbal skills but he is struggling in reading, writing, and spelling. It is reported that [Claimant] has improved in his articulation skills. He has good language skills and vocabulary for his age. He speaks in complete sentences, but he needs to continue working on the parts of the speech that he has difficulty with, ie: substituting "Him for He; Her for She and Them for They. (Exhibit 5.)

9. On April 30, 2013 and May 28, 2013, Edward G. Frey, Ph.D. performed a psychological evaluation on Claimant. Dr. Frey found Claimant verbal and interactive with appropriate vocabulary, but with some mild articulation errors in his expressive speech. Claimant was friendly and engaging with Dr. Frey, and he appeared to enjoy the assessment sessions, asking to redo the block design subtest in the second session. Claimant was able to carry on a conversation with Dr. Frey, but "may be somewhat rigid in terms of topic." (Exhibit 1, page 3.)

10. Dr. Frey administered the Wechsler Intelligence Scale for Children which yielded average to high average results. On the Gilliam Autism Rating Scale-II, Claimant scored in the "possible" range for autism. That test placed him in the clinical range in the area of social interaction, but not in the areas of stereotyped behaviors or communication. Dr. Frey also administered parts of Modules 2 and 3 of the Autism Diagnostic Observation Schedule. Claimant did well in the area of language and communication. In the area of reciprocal social interaction, eye contact was better in the first assessment than in the second, a result Dr. Frey found to be "less than optimal," However, eye contact was never absent. Facial expression was appropriate, and Claimant "seemed to enjoy interaction particularly in the cognitive testing and unstructured play." (Exhibit 1, page 4.) Claimant's social response was good. Reciprocal communication was adequate, but the quality of his social overtures was "slightly less than would be expected." (*Id.*) His words were neither stereotyped nor idiosyncratic. Dr. Frey did not observe any unusual motor movements or unusual sensory interests. However, Claimant did show repetitive interests in his home play with Wii and Legos. Testing of social/adaptive functioning using the Vineland-II Adaptive Behavior Scales yielded results in the borderline range with communication as a mild deficit. In the Summary section of his report, Dr. Frey wrote in part:

> Current cognitive testing indicates [Claimant] is best viewed in the average range of intelligence. He has a superiority of nonverbal over verbal skills but both are average and nonverbal are high average. There is no evidence of mental retardation.
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> Regarding the issue of autism, current testing would not support assigning a DSM-IV diagnosis of Autistic Disorder to this little boy. He does not meet the clinical threshold either on the Gilliam Autism Rating Scale – II or the Autism Diagnostic Observation Schedule – 2. While there does appear to be some

> autistic like behaviors those seem primarily confined to the social area. Cognitive and verbal skills are markedly strong. Adaptive functioning generally seems borderline.
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> In summary, [Claimant] appears to currently display behaviors more consistent with the DSM – IV diagnosis of Asperger's Disorder than autistic disorder. This also is somewhat complicated by the existing diagnosis of ADHD,[4] the prescription of Adderall, and possible adjustment or emotional features.
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> In summary, [Claimant] does not present as a child with mental retardation. He does not appear to present as a child with autism based on DSM – IV criteria. It is possible he is presenting with Asperger's Disorder although this diagnosis is made somewhat provisionally at this time.

11, Dr. Frey diagnosed Claimant with Asperger's Disorder (provisional) and phonological disorder.

12. Psychologist Deborah Langenbacher, Ph.D. testified at the hearing. She explained that, by combining certain diagnostic categories from DSM-IV-TR, autism spectrum disorder in DSM-5 is diagnosed using only two categories. However, all of the criteria in those two categories must be satisfied in order for the diagnosis to be made. Dr. Langenbacher opined that, in this case, because Dr. Frey found that Claimant made eye contact, has friends, and lacks sensory difficulties, the DSM-5 criteria are not satisfied, and a diagnosis of autism spectrum disorder cannot be made.

13. Claimant's aunt, Anne L., took a contrary view. She testified that Claimant has friends only when they do what he tells them to do; that he plays baseball with a youth team but sits by himself during the games; that he has a bad temper and will be physically aggressive with peers when he does not get his way; that he struggles academically; and that he held his ears to protect them from the ambient noise at Disneyland.

14. Claimant's cousin, Jocie J., also testified. She stated that her brother (Claimant's other cousin) has been diagnosed with autism, and that Claimant acts just like him. However, Claimant and his male cousin do not like each other and do not interact. Instead, Claimant's entire interest centers on video games.

15. Both Anne L. and Jocie J. pointed out that the Service Agency saw Claimant for only two hours, while they live with him and observe his behaviors on a daily basis. Jocie J. testified that Claimant tries to make himself look good for certain people, implying that he did so with Dr. Frey.

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[4] See Factual Finding 16, below.

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16. Claimant has been a patient of La Puente Valley Mental Health Center since July 11, 2012, with a diagnosis of Attention Deficit Hyperactivity Disorder, (ADHD), Combined Type. He is prescribed Adderall SR, 15 mg for that condition. In an August 2, 2013 letter from medical personnel at that facility, Claimant was described as follows:

> [Claimant] is very active and has difficulty focusing in class and needs individual tutoring to complete his school work. [Claimant] does not seem to read social cues and has reported being left out at school and having few friends. [Claimant] reported that "the other children do not play the right way." [Claimant] has limited ability to engage in reciprocal conversation. In therapy sessions, [Claimant's] play was repetitive from week to week. [Claimant] was easily frustrated because he had very specific expectations and rules which he did not know how to communicate to therapist. [Claimant] did become more relaxed and secure in his relationship with [his aunt] in the past year.
> (Exhibit B.)

17. In June 2013, Claimant finished kindergarten for the second time. His teacher wrote a letter for the instant matter in which she stated in part:

> [Claimant] had difficulties in relating to peers when things didn't go his way, he became extremely unsettled. When he felt wrongly treated or accused, he became frustrated and angry, and no amount of reasoning quelled his upset. After an apology from peers, he frowned and pouted. He was very defensive, and always avoided apologizing for his offenses. Only if there was a penalty for not apologizing, would he reluctantly oblige and do so.
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> [Claimant] mostly stood at his desk to do his work in spite of reminders to remain seated. He was asked to use the sink in the classroom to wash [h]is hands during lessons daily for having his fingers in his nose. He was never one to hug or comfort another who had been hurt on the playground. He didn't seem to appreciate a hug from either adults or peers. His family reported that he prefers Star Wars videos and handheld games to interactive or constructive play.
> (Exhibit C.)

18. Dr. Langenbacher opined that the behaviors described by Claimant's teacher are consistent with ADHD. Her opinion is consistent with Claimant's diagnosis at La Puente Valley Mental Health Center, and the behaviors described in the center's letter (Exhibit B) are consistent with the behaviors observed by Claimant's teacher (Exhibit C.) In other words, the observations of Claimant's teacher, the observations of his treating clinic, and the opinions of Dr. Langenbacher are all consistent with a diagnosis of ADHD.

19. There is a history of drug and alcohol abuse in Claimant's family.

20. No evidence was offered to show that Claimant suffers from a condition similar to mental retardation or that he requires treatment similar to that for an individual with mental retardation.

LEGAL CONCLUSIONS

1. Claimant does not have a developmental disability entitling him to regional center services.

2. Various statutes and regulations relating to eligibility apply to Claimant's request for services. Welfare and Institutions Code section 4512 defines "developmental disability" as:

> a disability that originates before an individual attains age 18 years, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual. As defined by the Director of Developmental Services, in consultation with the Superintendent of Public Instruction, this term shall include mental retardation, cerebral palsy, epilepsy, and autism. This term shall also include disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation, but shall not include other handicapping conditions that are solely physical in nature.

3. California Code of Regulations, (CCR), title 17, section 54000 defines "developmental disability" as a disability attributable to mental retardation, cerebral palsy, epilepsy, autism, or other conditions similar to mental retardation or that require treatment similar to that required for mentally retarded individuals. The disability must originate before age 18, be likely to continue indefinitely, and constitute a substantial handicap. Excluded are handicapping conditions that are solely psychiatric disorders, solely learning disabilities, or solely physical in nature.

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4. The three exclusions from the definition of "developmental disability" under CCR, title 17, section 54000 are further defined therein. Impaired intellectual or social functioning which originated as a result of a psychiatric disorder, if it was the individual's sole disorder, would not be considered a developmental disability. "Such psychiatric disorders include psycho-social deprivation and/or psychosis, severe neurosis or personality disorders even where social and intellectual functioning have been seriously impaired as an integral manifestation of the disorder." (CCR, tit. 17, § 54000, subd. (c)(1).) Similarly, an individual would not be considered developmentally disabled if his/her only condition was a learning disability (a significant discrepancy between estimated cognitive potential and actual level of educational performance) which is not "the result of generalized mental retardation, educational or psycho-social deprivation, [or] psychiatric disorder . . . ." (CCR, tit. 17, § 54000, subd. (c)(2).) Also excluded are solely physical conditions such as faulty development, not associated with a neurological impairment, that result in a need for treatment similar to that required for mental retardation. However, a person with a "dual diagnosis," that is, a developmental disability coupled with either a psychiatric disorder, a physical disorder, or a learning disability, would still be eligible for services.

5. CCR, title 17, section 54001, subdivision (a) states:

> "Substantial disability" means:
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> (1) A condition which results in major impairment of cognitive and/or social functioning, representing sufficient impairment to require interdisciplinary planning and coordination of special or generic services to assist the individual in achieving maximum potential; and
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> (2) The existence of significant functional limitations, as determined by the regional center, in three or more of the following areas of major life activity, as appropriate to the person's age:
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> (A) Receptive and expressive language;
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> (B) Learning;
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> (C) Self-care;
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> (D) Mobility;
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> (E) Self-direction;
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> (F) Capacity for independent living;
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> (G) Economic self-sufficiency.

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6. In CCR, title 17, section 54002, the term "cognitive" is defined as "the ability of an individual to solve problems with insight, to adapt to new situations, to think abstractly, and to profit from experience."

7. To answer the question of Claimant's eligibility, several requirements must be met. At any point, a failure to satisfy a requirement will result in a conclusion of no eligibility. If all requirements are satisfied, eligibility is found, unless the Service Agency proves an exclusion.

8. A developmental disability must exist. That disability must be determined to fit into a category of eligibility. The condition must also constitute a substantial disability or handicap, and must not be or result solely from an excluded condition.

Autism/Autism Spectrum Disorder

9. DSM-5 details the diagnostic features necessary for a finding of Autism Spectrum Disorder, providing in part:

> The essential features of autism spectrum disorder are persistent impairment in reciprocal social communication and social interaction (Criterion A), and restricted, repetitive patterns of behavior, interests, or activities (Criterion B). These symptoms are present from early childhood and limit or impair everyday functioning (Criteria C and D). The stage at which functional impairment becomes obvious will vary according to characteristics of the individual and his or her environment. Core diagnostic features are evidence in the developmental period, but intervention, compensation, and current supports may mask difficulties in at least some contexts. Manifestations of the disorder also vary greatly depending on the severity of the autistic condition, developmental level, and chronological age; hence, the term *spectrum*. Autism spectrum disorder encompasses disorders previously referred to as early infantile autism, childhood autism, Kanner's autism, high-functioning autism, atypical autism, pervasive developmental disorder not otherwise specified, childhood disintegrative disorder, and Asperger's disorder.
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> The impairments in communication and social interaction specified in Criterion A are pervasive and sustained. . . . Verbal and nonverbal deficits in social communication have varying manifestations, depending on the individual's age, intellectual level, and language ability, as well as other factors such as treatment history and current support. Many individuals have language deficits, ranging from complete lack of speech through language delays, poor comprehension of speech, echoed speech, or stilted and overly literal language. Even when formal language skills (e.g., vocabulary,

grammar) are intact, the use of language for reciprocal social communication is impaired in autism spectrum disorder.

Deficits in social-emotional reciprocity (i.e., the ability to engage with others and share thoughts and feelings) are clearly evident in young children with the disorder, who may show little or no initiation of social interaction and no sharing of emotions, along with reduced or absent imitation of others' behavior. What language exists is often one-sided, lacking in social reciprocity, and used to request or label rather than to comment, share feelings, or converse. . . .

Deficits in nonverbal communicative behaviors used for social interaction are manifested by absent, reduced, or atypical use of eye contact (relative to cultural norms), gestures, facial expressions, body orientation, or speech intonation. An early feature of autism spectrum disorder is impaired joint attention as manifested by a lack of pointing, showing or bringing objects to share interest with others, or failure to follow someone's pointing or eye gaze. Individuals may learn a few functional gestures, but their repertoire is smaller than that of others, and they often fail to use expressive gestures spontaneously in communication. . . .

Deficits in developing, maintaining, and understanding relationships should be judged against norms for age, gender, and culture. There may be absent, reduced, or atypical social interest, manifested by rejection of others, passivity, or inappropriate approaches that seem aggressive or disruptive. These difficulties are particularly evident in young children, in whom there is often a lack of shared social play and imagination (e.g., age-appropriate flexible pretend play) and, later, insistence on playing by very fixed rules. . . .

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> Autism spectrum disorder is also defined by restricted, repetitive patterns of behavior, interests, or activities (as specified in Criterion B), which show a range of manifestations according to age and ability, intervention, and current supports. Stereotyped or repetitive behaviors include simple motor stereotypies (e.g., hand flapping, finger flicking), repetitive use of objects (e.g., spinning coins, lining up toys), and repetitive speech (e.g., echolalia, the delayed or immediate parroting of heard words; use of "you" when referring to self; stereotyped use of words, phrases, or prosodic patterns). Excessive adherence to routines and restricted patterns of behavior may be manifest in resistance to change (e.g., distress at apparently small changes, such as in packaging of a favorite food; insistence on adherence to rules; rigidity of thinking) or ritualized patterns of verbal or nonverbal behavior (e.g., repetitive questions, pacing a perimeter). Highly restricted, fixated interests in autism spectrum disorder tend to be abnormal in intensity or focus (e.g., a toddler strongly attached to a pan; a child preoccupied with vacuum cleaners; an adult spending hours writing out timetables). Some fascinations and routines may relate to apparent hyper- or hyporeactivity to sensory input, manifested through extreme responses to specific sounds or textures, excessive smelling or touching of objects, fascination with lights or spinning objects, and sometimes apparent indifference to pain, heat, or cold. Extreme reaction to or rituals involving taste, smell, texture, or appearance of food or excessive food restrictions are common and may be a presenting feature of autism spectrum disorder. . . .
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> Criterion D requires that the features must cause clinically significant impairment in social, occupational, or other important areas of current functioning. Criterion E specifies that the social communication deficits, although sometimes accompanied by intellectual disability (intellectual developmental disorder), are not in line with the individual's developmental level; impairments exceed difficulties expected on the basis of developmental level.
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> (DSM-5, pages 53-55.)

10. In the present cases, Claimant's behaviors, as described by the witnesses and in the documentary evidence, are indicative of some of the symptoms of autism/autism spectrum disorder. However, those behaviors, even viewed in concert, do not satisfy all of the diagnostic criteria set forth in the three categories of DSM-IV-TR or the two categories of DSM-5. Further, the testimony of Jocie J., that Claimant tries to make himself look good to certain people, tends to undercut a diagnosis of autism/autism spectrum disorder, a condition in which the symptoms are involuntary.

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Fifth Category

11. The term "disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation," as referenced in Welfare and Institutions Code section 4512, is not defined by statute or regulation. Whereas the first four categories of eligibility are very specific (e.g., mental retardation, epilepsy, autism and cerebral palsy), the disabling conditions under this residual, fifth category are intentionally broad to encompass unspecified conditions and disorders. There are many persons and groups with subaverage functioning and impaired adaptive behavior. However, the service agency does not have a duty to serve all of them. The fifth category does not provide unlimited access to all persons with some form of learning or behavioral disability.

12. While the Legislature did not define the fifth category, it did require that the condition be "closely related" (Welf. & Inst. Code §4512) or "similar" (CCR, tit. 17, §54000) to mental retardation. The definitive characteristics of mental retardation include a significant degree of cognitive and adaptive deficits. Thus, to be closely related or similar to mental retardation, there must be a manifestation of qualitative or functional cognitive and/or adaptive deficits which render that individual's disability like that of a person with mental retardation. This, however, is not a simple and strict replication of all of the cognitive and adaptive qualities or criteria to find eligibility due to mental retardation (e.g., reliance on I.Q. scores). If it were, the fifth category would be redundant. Eligibility under this category requires analysis of the quality of the claimant's cognitive and adaptive functioning and whether the effect on his/her performance renders him/her like a person with mental retardation.

13. To have a condition which requires treatment similar to that provided to mentally retarded persons is not a simple exercise of enumerating the services provided to such persons and seeing if claimant would benefit. Many people could benefit from the types of services offered by regional centers, such as counseling, vocational training or living skills training. The criterion is not whether someone would benefit. Rather, it is whether someone's condition requires such treatment.

14. In this case, Claimant has been tested and found to be of average intelligence. No evidence was offered to show he has a condition similar to mental retardation or that he requires treatment similar to that of an individual with mental retardation.

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ORDER

Claimant has not established his eligibility for services. Claimant's appeal of the service agency's determination that he is not eligible for services from the service agency is denied.

NOTICE

This is the final administrative decision. Both parties are bound by this decision. Either party may appeal this decision to a court of competent jurisdiction within 90 days.

Dated: August 16, 2013

_____/s/_____
H. STUART WAXMAN
Administrative Law Judge
Office of Administrative Hearings